Geriatrics, Palliative Care and Interprofessional Teamwork Curriculum

Module # 11 : Cultural Competency

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Module #11: Cultural Competency

I. Overview: As the United States becomes more ethnically diverse, health care providers must learn about the perspectives and values of a variety of cultural groups. The risk of cross-cultural misunderstanding is increasing as encounters between patients and providers of different backgrounds are becoming more common. There are serious ramifications of ignoring the impact of cultural diversity in the delivery of health care services. When different cultures collide and are not recognized, acknowledged and identified, common reactions of patient, family and health care provider may include denial, depression, isolation, avoidance, fear, frustration, guilt, anger, and resentment.

It would be impossible for health care providers to be educated about every culture's health care and treatment beliefs. Therefore it is imperative that health care providers understand and recognize their own cultural beliefs and background, and most importantly, have communication skills which enable them to understand the cultural beliefs of all individuals they encounter in a health care setting. Communication techniques which seek to overcome ethnically-based conflict and misunderstandings are particularly essential in the area of palliative and end of life care.

II. Learning Objectives

1. Define "cultural competence" and the principles of cultural competence.
2. Provide an overview of the older population with respect to minority representation.
3. Describe why it is important to consider the historical experiences of older ethnic populations when working with them.
4. Describe the different factors which health care providers must be aware of when working with different cultural groups.
5. Delineate the main components of a cultural assessment.
6. Identify communication considerations when providing care to members of ethnic groups issues when considerations.
7. Describe the effect of culture on end-of-life decision making.
8. Describe the importance of practitioner self-assessment in terms of values.

III. Definitions

A. What is culture? Culture is "the shared values, traditions, norms, customs, arts, history, folklore, and institutions of a group of people." [1]

B. What is "cultural competence"?

1. "Cultural competence is a set of cultural behaviors and attitudes integrated into the practice methods of a system agency, or its professionals, that enables them to work effectively in a cross-cultural situation." [2]

2. "Cultural competence in geriatrics is the ability to give health care in ways that are acceptable and useful to elders because it is congruent with their cultural background and expectations."

3. "Culturally sensitive health care is a phrase used to describe a health care system that is accessible and respects the beliefs, attitudes, and cultural lifestyles of professional and of patients." [3]

C. *Cultural Diversity* refers to differences between people based on treasured beliefs, shared teachings, norms, customs, language and meaning that influence the individuals' and families' responses to illness, treatment, death and bereavement. [4]

D. *Situational Ethnicity* refers to the fact that patients may reveal more of their traditional culture and beliefs depending on the social setting.

E. *Intraethnic Variation* points out that a person's life never encompasses all aspects of one culture but is an approximation, conglomeration of pieces of that ethnic culture. Practitioners must be especially responsive to subtleties within ethnic classes, for example Puerto Rican vs. Dominican.

IV. Demographics [5]

The percentage of minority citizens is growing:

A. In 1970, 16% of the population in the U.S. was a member of a minority group. In 1998, the proportion grew to 27%, and it is projected that it will be 50% by the year 2050.

B. The United States Census Bureau projects the following redistribution of the 65and over population between 2000 and 2050.

TOTAL	**2000**	**2050**
Non-Hispanic White	83.5%	64.2%
Non-Hispanic Black	8.1%	12.2%
Non-Hispanic American Indian and Alaska Native	0.4%	0.6%
Non—Hispanic Asian and Pacific Islander	2.4%	6.5%
Hispanic	5.6%	16.4%

C. On the average, elders from most ethnic groups use formal health care services and long-term care services to a lesser extent than their white counterparts, with the exception of emergency room visits and acute care.

V. The Acculturation Continuum [6]

A. The Acculturation Continuum is the degree to which an older person is acclimated to American culture.

B. Providers should be aware of the vast range in acculturation found among elders within each ethnic population. There are many different domains of culture and a person may differ in degree to which he or she is acculturated to the different domains affecting health care.

C. Indicators of acculturation include use of the English language, length of time in the United States, and the process of adaptation. However it is important to note that how long ago the patient emigrated may have no bearing on how "traditional" or "American" the patient is.

VI. Importance of Cohort Components to Consider within Culture

A. It is important to consider the historical experiences of older ethnic populations.

1.Cohort analysis helps us to understand the impact of these experiences on elders of varying ethnic groups.

2. It also helps us to take appropriate social histories and to understand the influences on the older client's trust and attitudes about health care.[7]

3. Refer to Table 1, "Cohort Experiences: African American, Indian American, Chinese American, and Mexican American Elders."

B. The following domains should be considered:

- Ethnic Identity
- Gender
- Age
- Differing abilities
- Sexual orientation
- Religion and spirituality
- Financial status
- Place of residency
- Employment
- Education level

VII. Varying Factors among Different Cultures

A. In order to provide the most effective healthcare, providers must be aware of a number of varying factors that exist across the different cultural groups. Such disparities may by a result of genetic variation, environmental factors, specific health behaviors, or factors of service delivery.

1. For instance, for men 65 years and older 73.5% of non-Hispanic Whites reported good to excellent health, whereas 59.3% of non-Hispanic Black and 65.4% of Hispanic men in this age group reported similar health. [8]

2. Similarly, for Medicare beneficiaries 65 and older, 4.4% of non-Hispanic White elders reported delays in accessing care due to cost, with the percentage being 9.5% for non-Hispanic Blacks. [9]

VIII. Components of Cultural Assessment[1]

A. Patient/Family/Community

- Birthplace
- Ethnic identity, community
- Decision making
- Language and communication
- Religion
- Food preferences/prohibitions
- Economic situation
- Health beliefs re: death, grief, pain
- Gender and power issues
- Views of patient and family about location of death
- Degree of fatalism or activism in accepting or controlling care and death
- How hope is maintained
- Sources of support within the community

IX. Some Main Cultural Differences[10] (Refer also to Tables #2 and #3)

A. Different cultures have different perceptions. It may be helpful to discuss these perceptions with the patient early on in the provider-client relationship.

1. Respect
   - Role of the elder, child, caregiver, provider, etc.
   - Trust/Mistrust and deference towards the healthcare provider.
   - Relationships among family members.

2. Death and Dying
   - What constitutes a good death?
   - What happens after death?
   - Attitudes towards life-sustaining treatment, advance directives.

3. Pain
   - Reason for pain (biological vs. punishment)
   - Behaviors concerning pain
   - Medication issues
   - Surgery

4. Independence
   - Value of independence with old age.

- Medical decisions made independently or within a family context.
- Preferred caregiving setting and other issues in caregiving.
- What older people should be told about their illnesses: some cultures prefer that medical information, particularly that of a life-threatening prognosis, be given to the family and not to the patient.
- Informed consent.
- Issues in dementia.
- Long-term care.

5. Traditions and Rituals
   - Transitions (e.g., birthdays, moving from independent to assisted living)
   - Holidays (e.g., food, decorations, songs, prayers)
   - Death (e.g., funeral preparations, shiva, burial, cremation)

6. Effect of Culture on End of Life Decision Making [11]

   - There is no single description of end of life preferences for any specific cultural group, but rather considerable variation.

   - Three primary issues where there is ethic variation is:
     ~ Communication of bad news
     ~ Locus of decision making
     ~ Advance planning for terminal illness

7. In a qualitative study by Bullock based on a sample of African-Americans (n =102) nearly three quarters of participants refused to complete an advance directive. The themes identified were:

   - Faith and spirituality-belief that what happens is God's plan
   - Perceptions of suffering-prolongation of life does not necessarily indicate suffering
   - Death and dying-are not to be discussed in terms of planning and anticipating
   - Social support network (friends and family) will provide care

   - Barriers-lack of knowledge about advance care planning, feeling of being pushed by health professionals

- Mistrust of the health care system-lack of trust that health professionals will respect the patient's and families' wishes. [12]

X. Individual Culture and the Patient-Practitioner Relationship [13]

A. Aspects in which cultural differences can affect the patient-provider relationship:

1. Language and cultural barriers between providers, patients, and patients' families.
2. Explanatory models of illness.
3. Dietary habits.
4. Medication compliance.
5. Alternative (non-Western) practices (e.g. herbal medicines)/belief in existence of non-biomedical illnesses or in the efficacy of scientific treatments.
6. Role of religion, with ethical dilemmas of life-sustaining interventions conflicting with religious beliefs.
7. Cultural attitude of some communities and families concerning expectations that patients should be cared for at home.
8. Western emphasis on "independence" as a goal of therapy.
9. Unrealistic expectations.
10. Different expectations as to entitlement to good medical care.
11. Difficulty establishing trusting relationships.
12. Ignorance of how the American medical system works and lack of skills in navigating it.
13. Patient is unable to verbalize his or her symptoms in detail.

B. Communication Considerations

1. Be creative in finding ways to communicate with population groups that have limited English-speaking proficiency.
2. Spend time listening to needs, views, and concerns of the community.
3. Ask the older patient for his or her preference for decision making early on in care.
4. Use the language and dialect of the people you serve.
5. Use communication vehicles that have value and use by your target audience.
6. Use a cultural broker or cultural guide from the elder's ethnic or religious. background.

C. Recognize cultural differences related to:

1. Conversation style
2. Personal space

3. Eye contact
4. Touch
5. Time orientation
6. View of healthcare professionals
7. Learning styles

D. Appoint a spokesperson

1. Ask the older patient to identify a family spokesperson.
2. In emergencies, ask the family to appoint a spokesperson.
3. Respect the appointment, even if the person is not a family member or does not live nearby.

E. Role of Family

1. Who makes the decisions?
2. Who is included in discussions?
3. Is full disclosure acceptable?

F. Physical Environment

1. Create culturally, linguistically friendly interior design, pictures, posters, and artwork to make facilities more welcoming.

2. Display material and information with recognizable props that hold significance, value, and interest for your target audience.

3. Put props in the hands of people that will maximize their distribution, circulation.

G. Policies and Procedures

1. Mission statement must articulate principles and rationale for culturally competent service delivery.

2. Develop structures to assure community participation in planning, delivery, and evaluation of services.

3. Institute procedures to recruit, retain, and train a diverse and culturally competent workforce.

4. Familiarize the interdisciplinary health care team with cultural explanatory models of the elder's conditions.

H. Population-Based Service Delivery

1. Appreciate the importance of culture while avoiding stereotypes.

2. Understand the socio-political influences that shaped your consumers' attitudes, beliefs and values.

I. Training and Professional Development

1. Provide informal opportunities for staff to explore their attitudes, beliefs, and values.

2. Recognize that cultural sensitivity occurs on a continuum.

3. Provide specialized training for interpreters.

J. Physical Examination/Assessment

1. Cross-gender physical examinations are unacceptable in many cultures.

2. Consider preference of presence of family member.

3. Ask permission to examine various areas of the body.

4. Preferred amount of information provided to the patient and family oftentimes varies.

5. Symptom recognition, report, and meaning may vary.

K. Proactive Attitudes and Activities Toward Cultural Sensitivity [14]

1. Seek information to enhance cultural awareness.

2. Consider own attitudes and behaviors that enhance or hinder relationships.

3. Evaluate use of terms of phrases that may be interpreted as degrading or hurtful.

4. Attended workshops on cultural diversity.

5. Openly disagree with racial, cultural or religious jokes, comments or slurs.

6. Create a culturally supportive environment with colleagues and patient/families.

XI. Values Clarification (Refer also to Table #4)

A. Culturally competent practice begins with values clarification on the part of the practitioner.

1. It is important that the healthcare provider be aware of his or her own feelings toward other cultures, ethnicities and races.
2. Cannot make assumptions based our own cultural norms and expectations.
3. Whereas elimination of cultural bias is very difficult, recognition of individual biases and expectations.

B. Health Professional's Self-Assessment [15]

1. What are your own beliefs about illness and death and how do they influence your attitudes?
2. How significant is religion in your attitudes toward illness and death?
3. What kind of death would you prefer?
4. If diagnosed with a terminal illness, whom would you want to tell?
5. What efforts should be made to keep a seriously ill person alive?
6. How would you want your body disposed of?
7. What is your experience of participating in rituals to remember the dead?

C. Values and Attitudes Underpinning Culturally Competent Practice[16]

1. Avoid stereotyping and misapplication of scientific knowledge.

2. Be knowledgeable about cultural differences and their impact on attitudes and behaviors.

3. Be sensitive, understanding, non-judgmental and respectful in dealing with people whose culture is different from your own.

4. Be flexible and skillful in responding and adapting to different cultural contexts and circumstances.

X. References

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XIII. Learning Resources

A. Tables:

Table 1: Cohort Experiences

COHORT EXPERIENCES - AFRICAN AMERICAN ELDERS

1900-1920	1920-1940	1940-1960	1960-1980	1980-Present
Urban Migration	Harlem Renaissance	WWII: Segregated Troops; factory work in North and West	Civil Rights Movement and Law	Jesse Jackson ran for President
NAACP and Urban League Founded	Marcus Garvey's back to Africa Movement	Desegregation in plants, schools and military.	Dr. Martin L. King, Jr. led non-violence and then was assassinated	Black Muslims
Ku Klux Klan Active	Klan marched on Washington	Montgomery Bus Boycott	Affirmative Action	Rodney King trial
WWI and the "Red Summer"	Depression	Jackie Robinson	Political Activism	Million Man & Woman Marches
	Jesse Owens and Joe Lewis		Kennedy assassinated	Declining Affirmative Action
			The Black Panthers	

COHORT EXPERIENCES – AMERICAN INDIAN ELDERS

1900-1920	1920-1940	1940-1960	1960-1980	1980-Present
Reservations	Citizenship	World War II Service	Vietnam War	Education of Professionals
"Vanishing American"	Adoption of Indian Children by Whites	Relocation by BIA to Urban Areas	Indian Activism	Litigation
Forced Boarding Schools	Loss of Land by Allotment System	Termination of 100 Tribes	Youths Return to Traditional Practices	Self-Determination of Tribes
Traditional Culture "Bad"	Forced Assimilation	Forced Assimilation	Urbanization for Education & Jobs	Urban Pan-Indianism
Law Banned Spiritual Practices	Boarding Schools			Reservation Gaming

COHORT EXPERIENCES - CHINESE AMERICAN ELDERS

1900-1920	1920-1940	1940-1960	1960-1980	1980-Present
Chinese exclusion act in effect	1924 Immigration Act Excludes all Asians	Repeal of Exclusion Act	New immigration act favors family members	Continued heavy immigration, from Taiwan, Hong Kong and Vietnam
Urbanization	Families emerge in Chinatowns	Chinese Americans in WWII	Increased educational opportunities	Seen as "Model Minority"
Immigration of "Paper Sons"	Family Associations	Immigration of wives	Continued discrimination in union employment	"Followers of Children"
Predominantly male	Pearl Buck novels	Fear of Chinese Communists		Anti-immigrant bias

COHORT EXPERIENCES – MEXICAN AMERICAN ELDERS

1900-1920	1920-1940	1940-1960	1960-1980	1980-Present
Heritage of Loss of Land	Massive Immigration	WWII Participation	Chicano Movement	Increasing Political Power
Mexican Revolution	Depression	Immigration	Bilingual Education	Anti-Immigrant Bias
	Repatriation	Urbanization	Latino Arts and Media	Welfare Reform Movement
		GI Forum	Deportation and Amnesty	Anti-Bilingual Education Trend

Source:
Yeo, G. et al. (2000). Core curriculum in ethnogeriatrics (2nd Ed.). Stanford University, California: Module 3.

TABLE 2: Major Systems of Culturally Based Health Beliefs

Biomedical Model (Western, Allopathic)	Biomedical model of medicine and nursing, the primary healing system of the dominant culture/group in the United States. Based on scientific reductionism and characterized by mechanistic model of the human body; separation of mind and body, and discounting of spirit or soul.
Traditions from American Indian Nations	Health beliefs and views of death predate European immigration and vary by tribe. Many are characterized by mind-body-spirit integration, spiritual healing, and use of herbs from native plants. Harmony with natural environment (e.g., animals, plants, sky, and earth) was important for health. Illness is sometimes seen as a result of an individual's offenses, to be treated by a ritual purification ceremony or a ceremony by a medicine person. In many tribes, life and death are viewed in a circular pattern rather than linear as in European traditions.
Traditions from Africa and Early African American Heritage	Various African traditions frequently integrated with American Indian, Christian, and other European traditions. In the variety of systems, most illness could be seen as: • a natural illness, which is a result of a physical cause, such as infection, weather, and other environmental factors; • a occult illness, which is resulted from supernatural forces, such as evil sprits and their agents (e.g., conjurers); or • a spiritual illness is a result of willful violation of sacred beliefs or of sin, such as adultery, theft, or murder Common characteristics of healing include: • healing power of religion, Christian in some cases; and • use of herbs, or " root working". In some Caribbean Islands, African traditions evolved into strong beliefs in power of spirits and use of healers to maintain health and treat illnesses. However, those beliefs probably have a weak influence on most urban African Americans today. Many current African American elders, particularly those from the rural South, grew up using alternative practices of self-treatment, partly in response to lack of access to mainstream care. Experiences of segregation and memories of the Tuskegee experiment may make the current cohort of older African Americans skeptical and distrustful of mainstream medicine, especially when making decisions about care at the end-of-life.
Traditions from Asia	Classical Chinese medicine influenced traditions in Japan (Kampo), Korea

	(Hanbang), and Southeast Asia. It is characterized by • need for balance between *yin* and *yang* to preserve health, especially through the use of herbs and diet; • unblocking the free flow of *qi*, (chi) or vital energy, through meridians in the body by acupuncture, *tai chi*, moxibustion, and cupping; and • interaction of basic elements of the environment (e.g. water, fire, earth, metal, and wood). In parts of Asia, Taoism and Buddhism have influenced the healing traditions. • Taoism emphasizes the need to adapt to the order of nature, and • Buddhism emphasizes meditation for spiritual and physical health. Ayurvedic medicine practiced in India: • is shaped by Hinduism and traditional Indian culture. • includes basic elements of the environment (e.g., air, water, and wind) which have analogues in the body. • is characterized by the use of yoga, meditation, herbs, and by integration of mind-body-spirit. Traditional Hmong health beliefs are characterized by: • interventions of a wide variety of spirits that promote health or cause illness; and • risk of loss of soul that brings illness. For many Asian American elders, traditional healers' offices serve as meeting places to socialize with other elders. The socialization function of traditional healing parallels the traditional Chinese medical view that illness should be addressed not only through medicine, but also through social and psychological aspects of life. End-of-life decisions about care may be characterized by: • family vs. individual decision making—even if the elder is competent to make decisions, family members might feel that it is their filial duty to take the decision-making role; • non-disclosure of terminal illness to protect the elder; and • placement of the dying person or the body—wanting to "go home to die" and the practice of not disturbing the body reflecting reluctance of organ donation or autopsy.
Traditions from Latin	

America	Most Latino Americans practice the biomedical model, but among some elders there may be reminiscences of other beliefs. • Beliefs rooted in models developed from Native American, European, and African practices form an intricate cultural blend. Examples are *Santeria, Espiritismo,* and *Curanderismo*, in which religion is an important component of the system. • CAM practices are seen as exogenous, and in opposition, to the biomedical model. There is an integration of elements from both practices forming a complex cultural product. Latino Americans are less likely than European Americans to: • make individual decisions on end-of-life issues or complete advance directives, • endorse the withholding or withdrawal of life prolonging treatment, • use hospice services, • support physician-assisted death, and organ donation. Cultural themes that can influence beliefs and practices concerning end-of-life decisions may include the emphasis on the well-being of the family over the individual; respect for hierarchy; and the emphasis on the present as opposed to past or future.
Other European American Systems	Folk healing systems from European countries predating biomedicine, many of which include religious healing and use of herbs, may still be practiced in some areas of the U.S. Variations on the belief systems of allopathic medicine, or competing health philosophies have emerged in the U.S. in the past century. Two of the major ones are: • Osteopathy, similar to allopathic medicine, but deals with the "whole person" and emphasizes the interrelationship of the muscles and bones to all other body systems; • Homeopathy emphasizes the healing power of the body, and relies on the "law of similars" to choose drug therapy.

*SOURCE: Yeo, G. etal. Core Curriculum in Ethnogeriatrics, Second Edition. Stanford University, California. 2000. Module 3.

TABLE 3: Multicultural Outcomes: Guidelines for Cultural Competence

Summary of the Domains of Culture

Domain	Description
Ethnic Identity	Country of origin, ethnicity/culture with which the group identifies, current residence, reasons for migration, degree of acculturation/assimilation, and level of cultural pride.
Communication	Dominant language and any dialects, usual volume/tone of speech, willingness to share thoughts/feelings/ideas, meaning of touch, use of eye contact, control of expressions and emotions, spokesperson/decision maker in family.
Time and space	Past, present, or future orientation; preference for personal space and distance.
Social organization	Family structure; head of household, gender roles, status/role of elderly; roles of child, adolescents, husband/wife, mother/father, extended family; influences on the decision-making process; importance of social organization and network..
Workforce issues	Primary wage earner, impact of illness on work, transportation to clinic visits, health insurance, financial impact, importance of work.
Health beliefs, practices, and practitioners	Meaning/cause of cancer and illness/health, living with life-threatening illness, expectations and use of Western treatment and healthcare team, religious/spiritual beliefs and practices, use of traditional healers/practitioners, expectations of practitioners, loss of body part/body image, acceptance of blood transfusions/organ donations, sick role and health-seeking behaviors.
Nutrition	Meaning of food and mealtimes, preferences and preparation of food, taboos/rituals, religious influences on food preferences and preparation.
Biological variations	Skin, mucous membrane color, physical variations, drug metabolism, laboratory data, and genetic variations-specific risk factors and differences in incidence/survival/mortality of specific cancers.
Sexuality and reproductive fears	Beliefs about sexuality and reproductive/childbearing activities, taboos, privacy issues, interaction of cancer diagnosis/treatments with beliefs about sexuality.
Religion and spirituality	Dominant religion; religious beliefs, rituals, and ceremonies; use of prayer, meditation or other symbolic activities; meaning of life; source of strength.
Death and dying	Meaning of dying, death and the afterlife; belief in fatalism; rituals, expectations, and mourning/bereavement practices.

Source: Oncology Nursing Society (1999). Oncology Nursing Society Multicultural Outcomes Guidelines for Cultural Competence. Pittsburgh, Pa. Auth. Reprinted with permission.

TABLE 4: Cultural Self- Assessment

1. Where were you born?

   If an immigrant, how long have you lived in this country?
   How old were you when you came to this country?
   Where were your grandparents born?

2. What is your ethnic affiliation and how strong is your ethnic identity?

3. Who are your major support people: family members, friends?
   Do you live in an ethnic community?

4. How does your culture affect decision regarding their medical treatment?

   Who makes decisions - you, your family, or a designated family member?
   What are the gender issues in your culture and in your family structure?

5. What are your primary and secondary languages, speaking and reading ability?

6. How would you characterize your nonverbal communication style?

7. What is your religion, its importance in your daily life, and current practices?

   Is religion an important source of support and comfort?

8. What are your food preferences and prohibitions?

9. What is your economic situation, and is the income adequate to meet the needs of you and your family?

10. What are your health and illness beliefs and practices?

11. What are your customs and beliefs around such transitions as birth, illness and death?

    What are your past experiences regarding death and bereavement?
    How much do you and your family wish to know about the disease and prognosis?
    What are your beliefs about the afterlife and miracles?
    What are your beliefs about hope?

Adapted from: Zoucha, R (2000). The keys to culturally sensitive care. American Journal of Nursing, 2000:24GG-2411

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Table 5: Competencies Important for Ethnogeriatric Practice

Practitioners should be able to:

- Describe their own cultural values and discuss the effect of those values on their behavior and beliefs.
- Assumes and acknowledge the heterogeneity within categories and groups of ethnic elders.
- Assess clients' position on the continuum of acculturation in relation to their perceptions, definitions, and explanatory models of health and illness and their health behaviors.
- Demonstrate interviewing skills which promote shared decision-making and mutual respect between the ethnic client and the health care provider.
- Communicate effectively and elicit information from elders of any ethnic background.
- Explain the importance of cultural and historical experiences (e.g., racism and discrimination) and describe their effect on the older client's help-seeking behavior.
- Identify the resources within older individuals and the ethnic community for promoting and maintaining elders' health, and support those resources in a respectful way.
- Advocate for the institutionalization of policies and practices that facilitate ethnically sensitive health care within organizations and professions.

Source: Yeo, G. et al. (2000). Core curriculum in ethnogeriatrics (2nd Ed.). Stanford University, California:

TABLE 6: Ten Tips for Communicating with Patients from Other Cultures

1. Spend a few minutes in small talk at the beginning of the visit before getting down to the medical task at hand. This can be done in English, or if your language skills are sufficient, in the patient's native tongue.

2. Show respect for the patient's beliefs about illness and health care.

3. Don't assume the patient dislikes you, doesn't trust you, or isn't listening because he or she avoids eye contact.

4. Determine what other culturally determined heath care resources and methods the patient has used or continues to use while under care.

5. Verify how the patients will take the medication or follow the treatment plan.

6. Don't assume that the patient understands you and will follow your medical advice simply on the basis of his or her nod and a verbal, "Yes, yes."

7. Be aware of the basic beliefs, values, and mores of various cultures.

8. Understand the value of the family's presence and role in the illness and recovery process.

9. Use an interpreter whenever appropriate.

10. Don't stereotype cultures ("All Mexican Americans like to be touched, all Asians do not")

SOURCE: Joanne Desmond, The personal touch, Life in Medicine, Sept 1994; p.9

Learning Resource B: Case Studies

Case Study 1: Mrs. Mendez

Mrs. Maria Mendez is a 72-year-old Hispanic patient with advanced left breast cancer with metastasis to the lungs and bones. She is referred to your home care agency for wound care services. She has seven children: five daughters and two sons (all living in California). Her five daughters live within the Los Angeles area. Her eldest son lives in San Diego and the younger son has been distant from the family and has not had contact with the family for the last 18 months. Mrs. Mendez's husband died seven years ago of lung cancer. Since that time she has lived with her youngest daughter, Maria.

Initially, Mrs. Mendez discovered the breast lump herself but did not seek medical care for over a year. When Mrs. Mendez was diagnosed, her disease was considered advanced. She refused to have a mastectomy based in part by her cultural belief that the soul resides in the breast and should not be removed. At the urging of her children, she did undergo chemotherapy but recently has experienced increased bone pain and decided to discontinue the treatment regimen. The tumor in the left breast is now approximately the size of an orange with malodorous, purulent drainage. Home care was initiated for wound care and other symptom management services. Under the terms of her managed care/Medicare insurance plan, her care is referred back to her family care practitioner in her local community rather than her oncologist since she is no longer receiving cancer treatment.

Mrs. Mendez's condition continues to decline and her physician encourages her to seek hospice care. Mrs. Mendez has become very close to the home care nurses who provided the wound care and requests that her care continue with the home care agency rather than a referral to hospice. At this time, changes in her living arrangements are also made. Living with Maria over the last seven years has been very positive, but Maria has three young children and the intensive care of her mother at t his stage of the illness is becoming a problem. The family emphasizes that Mrs. Mendez should move in with her eldest daughter, Gloria, who no longer has children living at home. Although her daughters have always been close to their mother and more involved in her care, the eldest son of the family, Jose, who resides in San Diego, is consulted for all decisions and has been the father figure of the family since Mr. Mendez's death. Mrs. Mendez's managed care plan allows for only two RN visits per week and must be reevaluated every three weeks by the case manager. In addition to the symptom management provided by the home care agency, Mrs. Mendez and her daughters use many alternative therapies which includes "cat's claw", herbs, and visits by a healer. Mrs. Mendez is religious and uses prayer to help cope with her illness. Her middle-daughter, Christina, is devout in her religion and is in absolute denial that her mother will die. Christina comes nightly and holds a prayer vigil with her mother and also brings herbs and remedies that "will cure the disease". Mrs. Mendez becomes increasingly withdrawn as conflicts arise among her children. Gloria and Christina are at odds because

Gloria is most accepting of her mother's impending death. Gloria was also the primary caregiver during her father's illness with lung cancer.

After three weeks of care by the home care agency (HCA), Gloria calls requesting that a nurse come as soon as possible because her mother's pain is worse. On physical assessment, the nurse notes that the breast tumor remains dry, however the tumor mass has increased and the breast is inflamed. The pain is described by Mrs. Mendez as an intense pressure pain at the site of the tumor in the base of the breast. She also describes a sharp stabbing pain in the left upper quadrant of the breast. In addition, Mrs. Mendez complains of intense pain in her mid-back which has made it very difficult to lay in bed and she has been unable to sleep for the last week. She has been taking one to two Vicodin every four hours PRN although yesterday Gloria reports that out of desperation the Vicodin was given approximately every two hours until Mrs. Mendez became extremely nauseated. The nurse recalls that morphine was ordered for the patient a few weeks ago in anticipation of increased pain not controlled with the Vicodin. Upon questioning, the daughter states that they have not used the morphine as they were "Saving it for the end." Gloria also reports that the family is trying to minimize the use of the medicine since their mother is extremely constipated. Gloria continues to relate that the reason her mother is constipated is because Mrs. Mendez has not been able to continue her herbal remedies due to nausea. Mrs. Mendez appears very stoic with minimal expression of pain. Her only complaint is that she no longer is able to have her grandchildren over to visit due to her declining condition.

Mrs. Mendez is initiated on a regimen of long-acting morphine, 60 mg at bedtime with 15 mg morphine immediate release (MSIR) for rescue dose. Over the next week, the long-acting morphine is increased to 120 mg BID supplemented with Imipramine 50 mg BID and Ibuprofen 800 mg TID. Christina has now moved into Gloria's home and continues her evening prayer vigils. Jose calls several times a day to dictate his wishes regarding his mother's care but has not been able to visit often from San Diego as he is in risk of losing his job. Gloria seems increasingly burdened with her mother's care and her siblings' involvement. Gloria follows the home car nurse to the car weeping because of the stress.

Approximately one week later, the nurse receives a call from Gloria reporting that her mother has seemed to decline rapidly over the weekend. Mrs. Mendez awoke during the night with difficulty breathing and has been terrified of the possibility of suffocation. On exam, the nurse notes that Mrs. Mendez has developed extreme shortness of breath. She is also increasingly fatigued and the combination of exhaustion, dyspnea, and general decline has resulted in minimal intake of foods or fluids. Jose called this morning with strict orders that his sisters continue to feed their mother at all costs. He hopes to be able to come up from San Diego the following weekend to visit. Mrs. Mendez relates to the nurse that she knows she is dying and does not want to continue being a burden to her family.

Mrs. Mendez's physical condition has greatly improved due to aggressive symptom management by the HCA. The morphine does has increased to 240 mg BID supplemented with 40 mg of MSIR approximately every two hours for dyspnea. With her breathing improved, she as been able to take sips of water and occasional amounts of other liquids.

Mrs. Mendez's condition, however, continues to decline and the home care nurse anticipates that she will die within the next two weeks. The HCA schedules a meeting with the primary nurse and social worker to discuss the growing tension in the family. Four of the daughters are now present in the home taking shifts to be at Mrs. Mendez's bedside at all times. To make the family situation more difficult, Jose has learned that the young brother Pablo is living in Los Angeles and asks Pablo that he please visit his mother before she dies. Christina continues her prayer vigils and has asked members of her church to visit daily to hold prayer meetings with her mother. Mrs. Mendez tells the nurse that she cannot discuss her impending death with her family because they do not want to talk about it or hear that she is dying. At this point, Mrs. Mendez is very withdrawn and has little interaction with her family. Mrs. Mendez has now developed a pressure ulcer on her buttocks and requires a Foley catheter due to incontinence, which has intensified the physical care demands of her care.

The HCA receives a call on Saturday evening requesting assistance with Mrs. Mendez as her condition is declining rapidly. The younger son, Pablo, arrived two days ago and has had a very tearful reunion with his mother and his sister, Gloria. The social worker and the nurse were very successful in the family meeting with facilitating communication among the children and establishing common goals for Mrs. Mendez's comfort. All of the children with the exception of Christina, seem accepting of the impending death. Gloria's husband, Michael, has been quite supportive of his mother-in-law's care throughout her illness, but has strong feelings against death occurring within his home.

The priest is called to give Mrs. Mendez communion and the Anointing of the Sick. The extended family is at Mrs. Mendez's bedside, except for Christina who is in the kitchen crying.

Discussion Questions:

1. Use a cultural assessment tool to identify factors that influence care in this case.

2. How did culture influence communication with patients and family caregivers in this case.

3. Describe the roles of various professional disciplines in this case. How best could these professional coordinate their care?

SOURCE: ELNEC Curriculum. 2000. Module 5, p18-20.

Case Study # 2 : Mr. Seaung

The following case highlight issues from a particular culture that have an impact on decisions about a plan of care.

Rom Seaung is a 75-year-old widower from Cambodia who arrived in the United States in 1981. He lives with his 50-year-old widowed daughter and his three grandsons, ages 18, 20, and 22. His 20-year-old grandson's wife, who attends the University of Houston studying business administration, works and also lives in the home. The total number of persons in the three bedroom Heights' pier-and-beam home is six. Mr. Seaung's 72-year-old sister lives with his niece in Southwest Houston.

Mr. Seaung, who is unable to speak English, has his daughter, Ms. Veth, interpret in broken English. She is the one who made the clinical appointment for her father. Ordinarily, he frequents the traditional pharmacy and visits a shaman for health problems. Mr. Seaung prefers to visit the traditional healer rather than utilizing the Western medical system.

Ms. Veth reports that her father refuses to bathe, is not eating, and has bladder incontinence. She also reports that he has insomnia and at one time was diagnosed at an emergency room as having a stomach ulcer. The traditional healer removed the evil spirits, according to Mr. Seaung, and his ulcer problems seemed to dissipate. Mr. Seaung's appearance is disheveled. He appears to be quite skinny and is reluctant to participate in the examination. Ms. Veth reports that she wants her son's wife to assist with respite and supervision of her father. You feel uncomfortable because the daughter seems to be answering for Mr. Seaung and also seems in your opinion to intimidate her father, through you cannot be sure. Ms. Veth continues to complain that her daughter-in-law will not assist in bathing Mr. Seaung or providing assistance with her grandfather-in-law's care.

Mr. Seaung is living on Supplemental Security Income (SSI) and also has a Medicaid card. He also benefits from his family's paying most of the household expenses. His daughter is presently unemployed. In Cambodia, she was a seamstress and utilized those skills from 1985 to 1990 in the United States. She left work to take care of her sick husband who died a year later (1991). She never returned to work. She appears to be the only person providing informal support for her father.

Mr. Seaung's 18-year-old grandson is completing his last year of high school and is working to save money to attend a college out of state. His 22-year-old grandson graduated from Houston Community College and is working as a draftsman, while his 20-year-old grandson is also working and pursuing premed studies at the University of Houston. He hopes to attend medical school next year.

Upon examination, the nurse practitioner discovers that this patient has bruises up and down his arms and back. The bruises resemble large hematomas. Mr. Seaung's blood pressure is 100/60 mm Hg, and he has a slow irregular heartbeat and a temperature of 100°F.

SOURCE: Reproduced from Geriatric Interdisciplinary Team Training: A Curriculum from the Huffington Center on Aging at Baylor College of Medicine, edited by Dianne M. Long and Nancy L. Wilson (New York: John A. Hartford Foundation, Inc., 2001).

Case Study #3: Mr. Vega

Mr. Vega is an 83-year-old Hispanic with a history of dementia with alcoholic psychosis. Mr. Vega comes from a traditional Mexican background with an extended family that reflects a blending of traditional and acculturated views about family values, roles, and responsibilities. Mr. Vega also has a history of using folk remedies for ailments as complementary therapies to conventional health care. Mr. and Mrs. Vega were both born in Mexico and became naturalized; however, all their children were born in the United States. Mr. Vega worked as a mechanic and Mrs. Vega was a homemaker and on different occasions worked as a domestic worker. He has been diagnosed as having alcohol-related dementia, Alzheimer's disease, seizure disorder, and hypertension. Monthly income comprises his Social Security ($687) and his wife's Social Security benefits ($258). They have no other liquid assets. He scored 18/30 on the Mini Mental State Exam (MMSE) administered at the outpatient clinic. His wife, also a clinic patient, reports Mr. Vega has had a continuous cognitive decline, which was first noted several years earlier. He has an unsteady gait, and has fallen several times. He also exhibits condescending and aggressive behavior, particularly toward his wife and two daughters. The youngest daughter, age 45 and single, is employed and resides with the couple, but usually is only home at bedtime and provides no patient care assistance. The other daughter, the eldest, resides across town and provides transportation to the couple for medical appointments. She is divorced and is the sole provider for three children. Mr. Vega frequently berates this daughter for her inability to keep her husband in the home.

The couple also has three sons (two reside in Houston and one resides in Austin) who provide little daily assistance due to family commitments. No relationship between Mr. Vega and his sons appears to exist, at least in part because of his history of drinking and abusiveness. Other reasons may relate to their perceptions of family caregiving and their commitment to provide for their own families first. Mr. Vega's psychotic symptoms include being verbally explicit with his sons and imagining a sexual relationship between his wife and a man whom Mr. Vega "sees" frequently in their home. In fact, Mr. Vega's inappropriate sexual comments and behaviors almost resulted in a physical altercation with one of his sons; therefore, Mrs. Vega has requested that the children no longer visit. Mr. Vega has a 20-year history of becoming intoxicated daily before returning home from work. He allegedly had numerous extramarital affairs and was frequently verbally and physically abusive to his wife. Mr. Vega requires assistance with most activities of daily living. Mrs. Vega is medically stable, but is experiencing severe caregiver burnout. She scored 10/15 on the Geriatric Depression Scale (GDS) at the time of initial assessment. She refuses nursing home placement for Mr. Vega. She keeps the outside gate locked to prevent Mr. Vega from walking to the local bar. Mr. Vega has a Medicare health maintenance organization (HMO).

One month ago, Mr. Vega was admitted to a skilled nursing facility for physical therapy after being diagnosed with a compression fracture, secondary to falling. The facility had a contract with Mr. Vega's HMO. The family has experienced difficulty in dealing with any long-term placement decision due to cultural, social, and economic reasons. The case was referred to the interdisciplinary team for staffing.

Throughout the following year, the social worker became the primary mediator of conflicts between Mr. Vega and his wife, Mr. Vega and the adult children, and Mrs. Vega and the adult children. Multiple referrals for psychosocial intervention were made by the interdisciplinary team to various agencies. Mr. Vega's cognitive status continued to decline, affecting his physical status. His MMSE score is 10/30. As the result of a fall, Mr. Vega has been readmitted to the skilled nursing facility for physical rehabilitation. Mr. Vega has become almost totally dependent on the facility's care. His aggressive behavior has lessened.

Mrs. Vega scores 6/15 on the GDS. She states that she feels stronger emotionally; however, she acknowledges the progression of the dementia and her own physical exhaustion, which prevents her from providing optimal care for her husband. She reports that, most family members are working and are unable to provide any daily assistance.

SOURCE: Reproduced from Geriatric Interdisciplinary Team Training: A Curriculum from the Huffington Center on Aging at Baylor College of Medicine, edited by Dianne M. Long and Nancy L. Wilson (New York: John A. Hartford Foundation, Inc., 2001).